

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF SYPHILIS FOLLOWING THE BITE OF A HUMAN BEING.

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A WOMAN, aged 55 years, who was sent by her medical attendant to the Throat Hospital, Manchester, for further treatment gave the following history of her symptoms. On August 11th, 1905, she was bitten on the back of the hand by a woman and a sore which required about six weeks to heal subsequently formed at the place. About five weeks after the bite spots began to appear on her body and a little later her hair began to come out.

When the patient was seen by me on Dec. 22nd the sore on the hand was quite healed, leaving a dark red scar of the size of a florin. The rash had quite disappeared but the woman was still suffering from condylomata. Her mouth showed several mucous patches, especially on the inner surface of the lips. In the larynx there was considerable infiltration of the inter-arytenoid region, with ulceration of one vocal cord. The patient is a widow; but there seemed to be no reason for believing that the disease had been contracted in any other way and her medical attendant has informed me that a primary sore developed at the seat of the bite. The comparative rarity of the communication of syphilis in this way seems to make the case worthy of record.

Manchester.

A CASE OF HÆMATOCELE OF THE SPERMATIC CORD.

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THE patient, who was a tall youth of average build and 20 years of age, was playing cricket on August 26th, 1905, as wicket-keeper, when a medium-paced ball struck him just above the left pubic spine. He did not feel much pain at the time and went on playing, the game not being at all delayed. About an hour afterwards he felt pain on walking and noticed that flexion of the thigh had become difficult owing to a feeling of stiffness. There was no sign of bruising but he found that there was a lump over the region of the left pubic spine. He rubbed the part regularly with embrocation but the pain was not relieved. He went to the out-patient department of the Bolingbroke Hospital on Sept. 5th, by which time the swelling over the pubic spine had subsided and some little discolouration of the skin had appeared.

On examination there was felt in the left side of the scrotum a tumour which was continuous with a considerable thickening of the spermatic cord above it. As the thickened cord was traced upwards its diameter gradually diminished but the upper limit was very indefinite, being situated about the centre of the external abdominal ring. At the upper margin of the scrotum the cord was two-thirds of an inch in diameter. It was rounded in outline and hard but it yielded slightly under the pressure of the finger. There were no signs of hernia, the thickened cord being raised on coughing. Continuous with the cord above and extending for two and a half inches downwards into the scrotum was a sausage-shaped swelling one inch in diameter, with a full rounded end, placed a quarter of an inch above the left testicle—this organ being raised half an inch higher than its fellow of the other side. In front and at the sides the scrotal tumour was rounded and perfectly smooth in outline and configuration; whilst on its posterior aspect the constituents of the cord could be left spreading over it, the vas deferens being easily traceable

throughout its extent. The tumour was firm but pliable to digital pressure. It was not transparent to transmitted light and was not reducible. It had no connexion whatever with the tunica vaginalis and there was no effusion present in the latter sac. The spermatic veins were not enlarged on either side. There was no weakness of the abdominal walls and the thickened cord was moveable from side to side. On Sept. 8th the scrotal tumour had extended further downwards and was in contact with the testicle but could be separated from it. Its lower extremity was larger, had become more flattened, and bulged into the tunica vaginalis.

The diagnosis was hæmatocele of the spermatic cord following an injury. The patient had never suffered from hernia, but his father had had an inguinal hernia all his life. The hæmorrhage in these cases seems to occur into a pre-existing sac, probably a portion of the funicular process, which has become closed at each end in the course of development. It is difficult to imagine how a diffuse hæmorrhage into the tissues of the cord could present the physical signs described above, especially the full rounded lower limit and the definite sausage-shaped tumour, as the blood in such a case would tend to gravitate still further downwards and to envelope the testicle.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

ST. GEORGE'S HOSPITAL.

A CASE OF PHLEBOLITHS SIMULATING SUBCUTANEOUS FIBROUS NODULES.

(Under the care of Dr. ROLLESTON.)

A WOMAN, aged about 50 years, was admitted into St. George's Hospital under the care of Dr. H. D. Rolleston on Nov. 18th, 1905, with subacute gastritis from which she rapidly recovered. She had twice had an "ulcerated sore throat," when a child and 12 years ago, but had never had rheumatism or chorea. The joints did not show any evidence of arthritis deformans and there was no sign of von Recklinghausen's disease (generalised neurofibromatosis).

Remarks by Dr. ROLLESTON.—The point of interest in this case was the presence under the skin over both shins of numbers of discrete, small, hard, painless, moveable nodules of the size of minute shot or less; these nodules were not attached to the bone or to the skin. There was a bunch of varicose veins on the inner side of the left thigh just above the knee and some small superficial varicose veins were visible over the front of both shins, but there was no manifest continuity between these veins and the small subcutaneous nodules. No similar nodules were found elsewhere in the body. There was some doubt as to the nature of these nodules, which closely simulated the well-known transient nodules seen in the acute rheumatism of childhood and, except for the absence of tenderness, resembled the nodules sometimes found in a number of conditions summarised by Dr. G. Newton Pitt¹ and Professor R. Stockman,² such as arthritis deformans, gonorrhœal rheumatism, "chronic rheumatism," influenza, and syphilis. One of the small nodules was therefore excised under cocaine. When cut across it had to the naked eye the appearance of a calcified vessel containing some calcareous material. After the necessary decalcification it was cut, the microscopic appearances being (*vide figure*) those of a vein with some calcification of its walls and calcareous material occupying its lumen; there were no recognisable blood corpuscles in it. The nodule would therefore appear to be a dilated portion of a vein in which

¹ G. N. Pitt: Transactions of the Clinical Society, vol. xxvii., 1894, p. 54.

² R. Stockman: The Causes, Pathology, and Treatment of Chronic Rheumatism.